MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6533 State File Number 62-024690

DO NOT WRITE ON THIS STUB — AMENDED

FILED JUL 12 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 30yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: D.O.A Homer Phillips Hospital X
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1011 North Vandeventer Ave
Reside on Farm Yes ☐ No XX

3. NAME OF DECEASED (Type or print): First REV Middle ABE Last GUIDEN

4. DATE OF DEATH: Month June Day 29 Year 1962

5. SEX: Male
6. COLOR OR RACE: Col
7. Married ☐ Never Married ☐ Widowed ☐ Divorced X
8. DATE OF BIRTH: 10-2-1896
9. AGE (last birthday): 65
IF UNDER 1 YEAR Months 8 Days 27
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Kerr Ark
12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: Arthur Guiden
13b. MOTHER'S MAIDEN NAME: Annie Johnson
14. NAME OF HUSBAND OR WIFE: *

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv: No
16. SOCIAL SECURITY NO.
17. INFORMANT: Jacob Martin 4359 Finney Ave — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteria Sclerosis.
DUE TO (c): 420.1
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M Turner Deputy Coroner
22b. ADDRESS: 1300 Clark Ave
22c. DATE SIGNED: 6-30-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-3-1962
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St. Louis Co Mo

24. FUNERAL DIRECTOR ADDRESS: JAS H. RANDLE & SON 3133 Bell Ave
25. DATE RECD. BY LOCAL REG.: JUL 2 1962
26. REGISTRAR'S SIGNATURE: Raul Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Carter W. Harris

Licensed Embalmer No. 4458

P. O. Address 418 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.